A L	J
AB	

New □ or Update □

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS GEORGIA

Valid Application for Participation is mandatory for all training and competitions

4000 Dekalb Technology Parkway • Building 400, Suite 400 • Atlanta, Georgia 30340 • 770-414-9390 • Fax: 770-216-8339

Athlete Nan	ne	_
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SECTION A: ATHLETE HEALTH INFORMATION (SHOU	JLD BE SUBMITTED EVERY 3 YEARS)
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SECTION A: ATHLETE HEALTH INFORMATION (SHOULD BE SUBMITTED EVERY 3 YEARS)					
Social Security Number (Athlete) XXX — XX —		Birthdate	MEDICAL CLEARANCE PLEASE CHECK MEDICAL INFORMATION Does the athlete have:		
Athlete's Name (last name, space, first name)		M M D D Y Y Sex (M or F)	1. Heart Problems Yes □ No □ 2. Diabetes Yes □ No □ 3. Seizures/Epilepsy Yes □ No □		
A N			4. Major Surgery/Serious Illness Yes □ No □ 5. Parent/Sibling (under 40)		
Agency Name		Is the athlete employed? Yes No	died of heart disease Yes □ No □ 6. Down Syndrome Yes □ No □ If athlete is Down Syndrome, have x-rays of		
Addition 2 Mailing Addition		If so, where?	the C1-C2 vertebrae been taken and examined? Yes □ No □		
Athlete's Mailing Address	Background (optional):		Date of x-ray Does the athlete have Atlanto-axial		
	☐ African American ☐ Caucasia	ian Hispanic Native American	Instability? Yes □ No □ 7. Vision Problems/Blind Yes □ No □		
Athlete's City	Other		8. Hearing Loss/Deaf Yes □ No □ 9. Does athlete use wheelchair? Yes □ No □		
	Email		Other		
State Zip Code Parent's/Guardian's Daytime Telephone			Current Medications Dosage		
	Emergency Contact	Phone ()			
HEALTH INSURANCE & EMERGENCY INFORMATION					
Medicaid Number Health Insurance Company	Polic	y Number			
PARENT OR GUARDIAN AUTHORIZATION AND MEDIA RELEASE			Allergies (Medication, Food, Insect Bites):		
On my own behalf or as the undersigned parent or legal guardian of the above named athlete, I here					
I represent and warrant to you that the athlete is physically and mentally able to participate in Spec I understand that if the athlete has Down Syndrome he/she cannot participate in sports or events where the specific product is the specific participate of the specific product of the specific	Date of Last Tetanus Shot:				
upper spine unless a full radiological examination establishes the absence of Atlanto-axial Instabilit	*A HEALTH SCREENING BY A				
equestrian sports, artistic gymnastics, diving, pentathlon, high jump, alpine skiing, soccer, butterfly stroke and diving starts in swimming. On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to			LICENSED EXAMINER IS REQUIRED		
property of myself and the athlete. In permitting the athlete to participate, I am granting permission television, radio, films, newspapers, magazines, websites, and other media, and in any form not her	EVERY 3 YEARS FOR ATHLETES WITH "YES" CHECKED ON 1-5*				
of Special Olympics and in appealing for funds to support such activities. If I am not personally present at Special Olympics activities in which the athlete is to compete, so a	s to be consulted in case of necessity, you are	authorized on my behalf and at my account to take	SECTION B		
such measures and arrange for such medical and hospital treatment as you may deem advisable for and/or its agents to make an independent investigation of my background, including those maintain	the health and well-being of the athlete. By sig	gning this form I authorize Special Olympics	MEDICAL CERTIFICATION		
signing below I consent to participate in the Special Olympics Healthy Athletes program that provide	I have examined the above named athlete and, in my opinion, there is no mental or physical reason why he or				
vision; oral health possibly to include placement of sealants and fluoride varnish; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation to participate in the Healthy Athletes Program. I understand that when attending state events that there may be 2 or more people housed per room.			she should not participate in the Special Olympics sports training and competition program. Further information		
I, THE UNDERSIGNED ADULT ATHLETE, have read and fully understand the	I, THE UNDERSIGNED PARENT OR G	GUARDIAN of the above specified athlete.	will be forwarded if required. Current medication, if any, is specified with dosage on this application.		
provisions of the above release and/or have had them explained. I hereby agree that I	have read and fully understand the provisior them to said athlete. I hereby, agree that I a	ns of the above release and have explained	COMMENTS		
from disaffirmation thereof. I acknowledge and agree that the above information is shall defend Special Olympics Georgia and hold it harmless from disaffirmation thereof					
accurate.	y said minor. I acknowledge and agree tha	at the above information is accurate.	Examination Date		
	Signature of Parent		Signature		
	and/or Legal Guardian		Print Name		
Witness Date	Print Name	Date	CityState Zip		
A HEALTH SCREENING PERFORMED BY A LICENSED E	XAMINER IS REQUIRED FOR INI	ITIAL PARTICIPATION	Phone		

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION

SECTION A. - ATHLETE HEALTH INFORMATION/PARENT GUARDIAN AUTHORIZATION AND MEDICAL RELEASE

information, medications and allergies sections must be completed by a parent, guardian, or adult athlete. THE PERSON PROVIDING THE INFORMATION MUST SIGN AND DATE THE FORM IN THE SPACE PROVIDED. (IF SIGNED BY AN ATHLETE THERE MUST BE A WITNESS SIGNATURE). All athlete information, emergency information, health and accident insurance information, health

SECTION B - MEDICAL CERTIFICATION

The bottom section of the form labeled "Medical Certification" must be completed <u>SIGNED</u> and <u>DATED</u> by a licensed Physician, Physician Assistant or Chiropractor. A HEALTH SCREENING BY

PROVIDED in order for the State office to accept and process the Application. The State office should get the ORIGINAL WHITE COPY and the Local Coordinator should keep the YELLOW COPY All signatures, dates, addresses, phone numbers, birth date, health information MUST BE

A vs. AB APPLICATION FOR PARTICIPATION
The following guidelines will be used to determine "A" vs. "AB" applications:

- An Application will be considered an "A" Application if questions 1-5 of Section A are answered NO. When this application is up for renewal (every 3 years) only Section A - Athlete Health Information will need to be completed. No examiner's signature will be required under Section B - Medical Certification if application is completed before expiration date.
- An application will be considered an "AB" Application if any questions 1-5 of Section A are answered YES. An examiner's signature is required to have medical clearance of existing conditions. When this Application is up for renewal an examiner's signature is required.
- "AB" Application or vice versa. REMEMBER: If an application changes from A to AB or vice An athlete can have an "A" Application one time and the next time the Application could be an under Section B - Medical Certification.

A parent/guardian or an adult athlete must sign Section A of the Application for Participation. If Section A of the Application is signed by an adult athlete then a family member, friend or coach must also sign Section A of the Application.

fitness, each athlete's ability to train and complete in Special Olympics. SOGA offers six Healthy Athletes podiatry and physical therapy. The Healthy Athletes program is not mandatory; any athlete may elect not to go through the screening. Please call 770-414-9390 with questions about the program.